team-based care, continuity of care, access with continuity, interprofessional education and care, and resident engagement.

Participating programs rated the sessions highly. Eighty-nine percent of the programs rated the overall experience "excellent" (56%) or "good" (33%) at the midpoint evaluation. Comments from involved programs include: "an outstanding experience," "it has been wonderful to collaborate with other programs," "the collective passion in the room excited our group and provided the much needed impetus for new ideas and brainstorming…it's an exciting new wave for primary care and we are eager to be a part of it." Another participating group said: "We hope this initiative will continue to grow as we strive to continuously improve the ambulatory experience for our patients and our residents."

Based on the success of the first cohort, the board of AFMRD continued with another year of funding and 15 programs were selected from a competitive application pool for the second cohort which commenced February 2019.

Participating programs have shared their experiences in blog posts which can be found at: https://www.afmrd.org/p/bl/et/blogid=1014.

Across the country, family medicine residency programs are addressing the fundamental dilemma of a teaching clinic: harmonizing (1) the teaching mission which requires residents to be in many different rotations in order to learn the skills of a primary care physician, and (2) the patient care mission for which patients would like their physician to be available all the time. While it is not possible to perfectly accomplish both missions, many family medicine programs are making great progress for their residents and their patients.

Steven R. Brown, MD, FAAFP, Phoenix, Arizona;
Tom Bodenheimer, MD, San Francisco, California;
Marianna Kong, MD, San Francisco, California

References

1. Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med.* 2014;12(6):573-6.
2. Bodenheimer T, Ghorob A, Willard-Grace R, Grumbach K. The 10 building blocks of high-performing primary care. *Ann Fam Med.* 2014;12(2):166-71.
3. High-Functioning Primary Care Residency Clinics, 2016. Association of American Medical Colleges (AAMC). https://www.aamc.org/download/474510/data/aamc-ucsfprimarycareresidencyinnovationreport.pdf.
4. Gupta R, Barnes K, Bodenheimer T. Clinic first: 6 actions to transform ambulatory residency training. *J Grad Med Educ.* 2016;8(4):500-503.

AAFP From the American Academy of Family Physicians

Ann Fam Med 2019;17:471-472. https://doi.org/10.1370/afm.2450.

NEW AAFP INITIATIVE ADDRESSES RURAL HEALTH CARE CRISIS

Rural America is suffering from a health care crisis, a product of inadequate funding, economic downturn, and lack of an appropriate health care workforce. In response, the AAFP is launching Rural Health Matters, an Academy-wide strategic initiative to improve health care in rural communities.

Through this initiative, the Academy will seek to

- Develop and implement an integrated AAFP rural strategy
- Establish the AAFP as a leader for rural health and rural physicians
- Influence policy and payment issues related to rural health
- Address educational needs and resources for family physicians practicing in rural areas
- Support recruitment of family physicians to rural areas, including by increasing student choice, the number of residency positions and support for residency programs
- Create policy, collaboration and resources to help family physicians improve rural health disparities

The challenge is vast. We have lost more than 100 rural hospitals in this country in the last 10 years, including 10 already this year. More than 400 other hospitals are at risk of closing. This has created medical and obstetric deserts where there is no medical care for hundreds of miles. Most of these have been in communities with largely minority populations. These closures have greatly affected those living in poverty and those with low incomes, especially in areas where transportation poses challenges. Women and children in particular have been experiencing the brunt of this change in the health care landscape.

It is more dangerous to deliver a child in the United States now than it was 20 years ago. There are many reasons for this increase, but the lack of medical care in many rural communities is a significant component. If you are African American or Native American or Alaska Native, your risk of dying is much greater. If you live in a rural community without medical care, your risk is much greater. If you are a minority without access to care, your risk is compounded.

The underlying reasons for this crisis are multifactorial but include the lower payment family physi-

cians receive under Medicare, the impact of hospital and insurance consolidation, greater impact of poorly functioning electronic health records on solo and small independent practices, and the poor recovery of rural communities after the economic downturn.

This is not to say that inner-city underserved patients are not also in crisis, only that the health care situation in rural America is dire and has the potential to become much worse. The solutions to the rural health care crisis are also relevant to inner-city underserved patients. These populations share many problems with care access and delivery. The family physicians practicing in these locations share issues with payment, workforce, and scope of practice. Solutions for rural communities will benefit inner-city underserved communities, as well.

The AAFP task force on maternal mortality, created as directed by the 2018 Congress of Delegates, overlaps with the work of our rural initiative. The task force, which will report back to the COD in the fall, has been tasked with

- Evaluating evidence-based methods to decrease maternal mortality
- Reviewing methods to increase recognition of implicit bias and reduce disparities in maternal morbidity and mortality
- Developing strategies to help improve resident education and support practicing family physicians providing full-scope reproductive and maternity care
- Addressing the growing loss of rural maternity services nationwide

In my role as president of the AAFP and as a rural family physician who provides maternity care, I have participated in a variety of forums and venues, including national meetings of the American College of Obstetricians and Gynecologists and the National Rural Health Association as well as the National Governors Association's meeting on health care workforce development; the CMS Conversations on Maternal Care forum; the March for Moms in Washington, DC; and a hearing of the US Senate Committee on Finance.

At all these events I have been able to talk about the importance of a well-trained, comprehensive family physician workforce, and the impact this has on preventing hospital closures, as well as improving life expectancy and outcomes. I also talk about the importance of a robust loan repayment plan to encourage medical students to pursue rural family medicine as a career.

The AAFP has been developing stronger strategic relationships with NRHA, ACOG, the American Hospital Association, March for Moms, and the Rebuild Rural Infrastructure Coalition, among others. For example, we have been working with NRHA to prevent further hospital closures and reduce further obstetrical unit closures.

With regard to advocacy, we have been pushing for funding for teaching health centers, which we see as important for developing the family physician workforce the nation needs, especially in rural communities. In addition, we are advocating for removal of funding caps for hospitals that have had a previous rotating resident. We have vehemently argued that rural health care must be paid at a higher level, and that new payment models must take rural family physicians' practices into account.

As part of this initiative, the AAFP is working to ensure that rural family medicine is a part of the national dialogue. For example, the Academy has added a Rural Health Equity Fellowship to its Health Equity Fellowship program. The rural fellow will participate with the overall health equity program and in addition will have a rural curriculum, mentoring, and project relevant to rural health equity. The goal of the fellowship is to develop family physicians into leaders who have subject matter expertise in the social, institutional, and cultural influences that impact health. Fellows will become leaders who can facilitate change to improve their local communities and primary care.

Seventeen percent of our members practice in rural communities. Many provide obstetrical care and emergency medical services under some of the most challenging conditions possible. This strategic initiative has been created in recognition of the neglect rural communities have faced and the primacy of family medicine in delivering rural health care.

For those of you working in rural communities, thank you for what you do. Family physicians are the rural safety net.

John Cullen, MD
AAFP President

From the American Board of Family Medicine

Ann Fam Med 2019;17:472-475. https://doi.org/10.1370/afm.2457.

PURSUING PRACTICAL PROFESSIONALISM: FORM FOLLOWS FUNCTION

Still early in a long game of delivery system transformation, the United States is already experiencing some of the negative consequences of pursuing quality and value measurement on professionalism in health care, specifically in the form of provider burnout. Other countries have struggled with similar endeav-